(3) The maximum cap is the weighted average of the rates for routine services established by the department for the preceding 12 months for the category of long-term care facility, as adjusted by the inflation factor adopted by the department under 7 AAC 43.683.

(h) The department will express acute care hospital and specialty hospital rates as a percentage of charges and average rate per adjusted admission with anticipated medical assistance admissions and medical assistance adjusted admissions.

(i) The department will express long-term care facility and intermediate care facility for the mentally retarded rates as a per diem rate with anticipated medical assistance patient days and dollar amount per day that represents medical assistance patient-specific ancillaries.

(j) The department will determine a fair rate of payment for rural health clinics based on actual allowable costs for each occasion of service as determined by the medicare carrier under 42 C.F.R. 405.2426 — 2429 for the rural health clinic's fiscal year ending 12 months before the prospective fiscal year. The actual allowable costs will be adjusted as follows:

(1) Actual operating costs will be adjusted forward based on a compound rate of inflation as outlined in 7 AAC 43.683. The ancillaries will be separately identified from the clinic visit rate.

(2) The department will require revenue offsets, described in (b)(4) of this section, for determining a fair rate of payment for rural health clinics.

(3) The prospective payment rate will not exceed the payment limit set by the Health Care Financing Administration, U.S. Department of Health and Human Services, which is in effect 60 days before the rural health clinic's fiscal year begins.

(k) The department will express rural health clinic rates as a per-visit rate, with anticipated medical assistance visits and dollar amount for each visit, that represents medical assistance patient-specific ancillaries.

(*l*) The department will determine a fair rate of payment for outpatient surgical centers based on reasonable costs as determined under 42 C.F.R. 416.100 — 140.

(m) The department will determine a fair rate of payment for a hospital outpatient laboratory service based on reasonable costs as determined by the Medicare fee schedule.

(n) The department will express an outpatient surgical center rate as a four part per-procedure rate with anticipated Medical Assistance procedures.

(o) For assessments, reviews, and plans of care, the rate of a long-term care facility calculated under (a) — (g) of this section is adjusted upward by an increment that is the sum of the facility's medical assistance admissions during the base year multiplied by 3.91, plus the average number of medical assistance patients in the facility during the base year multiplied by 2.73, then multiplied by the product of 1.281 multiplied by the sum of the average registered nurse wage rate in the appropriate region plus half of the difference between that average registered nurse wage rate and the highest reported registered nurse wage rate in that appropriate region; the resulting product is then divided by the number of medical assistance patient days in the facility during the base year. If the base year allowable costs rather than the approved year rate are used in setting the facility's prospective rate and all or a portion of a facility's base year used in setting that rate includes any time after October 1, 1990, the rate increment under this subsection is reduced by the percentage of the base year, by month, that includes any time after October 1, 1990. This subsection takes effect October 1, 1990.

(p) For a computerized patient assessment system, the rate of a long-term care facility calculated under (a) — (g) of this section is adjusted upward by an increment that is the result of dividing $6,700 by the number of medical assistance patient days in the facility's base year. If the facility does not have a January through December fiscal year, the number of medical assistance patient days in the facility's base year used in the calculation under this subsection is the product of total base year medical assistance patient days divided by 12 months, multiplied by the number of months remaining in the fiscal year to accomplish payment of the $6,700 by the end of the fiscal year in progress on January 1, 1991. The adjustment applies only to the fiscal year in progress on January 1, 1991. This subsection takes effect January 1, 1991.

(q) For patient assessment system training, the rate calculated under (a) — (g) of this section of a long-term care facility not located in Anchorage is adjusted upward by an increment that is the result of dividing the sum of $285 and the August, 1990 round trip airfare between Anchorage and the location of the respective long-term care facility, as set out in this subsection, by the number of medical assistance patient days in the facility's base year. If the facility does not have a January through December fiscal year, the number of medical assistance patient days in the facility's base year used in the calculation under this subsection is the product of total base year medical assistance patient days divided by 12 months multiplied by the number of months remaining in the fiscal year to accomplish payment of amounts described in this subsection by the end of the fiscal year in progress on January 1, 1991. The adjustment applies only to the fiscal year in progress on January 1, 1991. The round trip airfares used in the calculation under this subsection are as follows:

Cordova	$180
Fairbanks	$278
Homer	$104
Juneau	$429
Ketchikan	$546
Kodiak	$346
Kotzebue	$522
Nome	$522
Petersburg	$508
Seward	$104
Soldotna	$ 94
Valdez	$167
Wrangell	$508

This subsection takes effect January 1, 1991.

(r) For quality assurance, the rate of a long-term care facility calculated under (a) — (g) of this section is adjusted upward by an increment that is the product of the facility's appropriate region's average registered nurse wage rate increased by 28.1 percent, multiplied by 96; that product is then divided by the number of medical assistance patient days during the base year. If the base year allowable costs rather than the approved year rate are used in setting the facility's prospective rate and all or a portion of a facility's base year used in setting that rate includes any time after October 1, 1990, the rate increment under this subsection is reduced by the percentage of the base year, by month, that includes time after October 1, 1990. This subsection takes effect October 1, 1990.

(s) For social services, the rate of a long-term care facility calculated in (a) — (g) of this section is adjusted upward by an increment that is the product of 5 multiplied by the number of admissions in the facility's base year, multiplied by a number that is the average social worker wage rate in the appropriate region increased by 28.1 percent, and divided by the number of medical assistance patient days during the base year. If the base year allowable costs rather than the approved year rate are used in setting the facility's prospective rate and all or a portion of a facility's base year used in setting that rate includes time after October 1, 1990, the rate increment under this subsection is reduced by the percentage of the base year, by month, that includes any time after October 1, 1990. This subsection takes effect October 1, 1990.

(t) For patient's rights, the rate of a long-term care facility calculated under (a) — (g) of this section is adjusted upward by an increment of $.05. If the base year allowable costs rather than the approved year rate are used in setting the facility's prospective rate and all or a portion of a facility's base year allowable costs used in setting that rate includes any time after October 1, 1990, the rate increment under this subsection is reduced by the percentage of the base year, by month, that includes any time after October 1, 1990. This subsection takes effect October 1, 1990.

(u) For admission agreements, the rate of a long-term care facility calculated under (a) — (g) of this section is adjusted upward by an increment that is the product of $2,500 divided by the number of medical assistance patient days in the facility's base year. If the facility does not have a July through June fiscal year, the number of medical assistance patient days in the facility's base year used in this calculation is the product of total base year medical assistance patient days divided by 12 months, then multiplied by the number of months remaining in the fiscal year, to accomplish payment of the amount described in this subsection by the end of the fiscal year in progress on July 1, 1991. The adjustment shall apply only to the fiscal year in progress on July 1, 1991. (Eff. 8/9/86, Register 99; am 7/4/87, Register 102; am 5/8/88, Register 106; am 6/19/88, Register 106; am 11/1/88, Register 108; am 2/3/89, Register 109; am 3/25/89, Register 109; am 6/18/89, Register 110; am 9/21/90, Register 116; am 8/28/91, Register 119; am 8/6/92, Register 123)

Authority: AS 47.07.070 AS 47.07.180

7 AAC 43.686. ALLOWABLE REASONABLE OPERATING COSTS. (a) The department will set prospective payment rates at a level sufficient to pay a fair rate for reasonable costs of a facility attributable to state programs. The department will consider only financial requirements that are consistent with efficient cost-effective management. The prospective payment rates will include operating costs that are directly related to the delivery of health care services. These costs include those incurred for patient services, education for accredited health-care-related programs and in-house training, and research if research efforts are approved in advance by the department. These costs will, in the department's discretion, include

(1) wages, salaries, and employee benefits;
(2) purchased services;
(3) supplies;
(4) utilities;
(5) depreciation, rental, lease;
(6) taxes, excluding local, state, and federal income taxes;
(7) interest expense;
(8) maintenance; and
(9) minor remodeling.

(b) Operating costs are the costs of providing health care services that are necessary and reasonable and that are not excluded in this section or by the manual.

(c) In its budget, a facility must reduce operating costs by the costs of activities other than health care services that generate revenue or financial benefits to the facility. If a facility sells goods or services to persons other than to patients, the amount of the reduction in allowable costs will be the actual costs of the item, service, or activity. In the absence of adequate documentation of costs, the amount of the reduction in allowable costs will be the amount of revenue received for an item, service, or activity. If financial benefits such as purchase discounts, courtesy allowances, or rebates are received, the amount of the reduction will be the amount of the discount or rebate.

(d) Types of operating costs include the following:

(1) Standards attainment. Costs that a facility incurs in providing health care and in meeting state and federal standards for providing health care are allowable costs. Costs are allowable only if they are documented, ordinary, and related to the provision of health care services to authorized Medicaid and General Relief Medical patients. Necessary and reasonable costs will, in the department's discretion, include

(A) meeting licensing and certification standards;

(B) meeting standards for providing patient care;

(C) fulfilling accounting and reporting requirements imposed by 7 AAC 43.679; and

(D) performing any patient assessment activity required by the Department of Health and Social Services.

(2) Abandoned planning projects. The costs of planning projects that are abandoned are allowable costs if they are amortized over not less than 60 consecutive months beginning with the month in which the project is considered abandoned in accordance with generally accepted accounting principles.

(3) Startup and organization costs. Startup costs and organization costs are allowable costs if they are amortized over not less than 60 consecutive months beginning with the month in which the first patient is admitted for care. Allowable organization costs include legal fees incurred in establishing the corporation or other organization, and fees paid to states for incorporation. They do not include costs relating to goodwill or to the issuance and sale of shares of capital stock or securities.

(4) Education and training costs. The following are allowable education and training costs:

(A) reasonable costs of on-the-job and in-service training directly related to health care services;

(B) reasonable costs of nursing assistant training;

(C) reasonable costs of training for volunteers, conducted by the health facility;

(D) reasonable costs of health-related community service training programs for other non-employees.

(5) Research costs. Reasonable costs of research directly related to health care services are allowable costs if they are amortized over not less than 60 consecutive months beginning with the month in which the research is completed.

(6) Management fees. The costs of a facility's home office that are reasonably attributable to the management of a facility are allowable costs for the facility. A facility must file with its annual budget any management agreement or change to a management agreement with a firm or individual, other than an employee, that will manage the facility during the period of the budget. Reasonable management fees paid to a firm or individual who is not an employee of the facility or of the facility's home office are allowable costs if

(A) the fees are paid according to the terms of a written management agreement that creates a principal/agent relationship between the facility and the manager, and sets out the items, services, and activities to be provided by the manager;

(B) the facility documents the actual delivery of management services;

(C) the services do not duplicate management services otherwise provided to the facility.

(7) Interest cost.

(A) Interest cost is allowable if the principal sum of the indebtedness is to be applied to a financial need of the facility and is to be applied for a purpose related to patient care. If the principal sum of an indebtedness is to be used for a business opportunity or for the purchase of goodwill, interest on the indebtedness is not an allowable cost.

(B) Interest cost is allowable if the rate of interest is not in excess of the rate that a prudent borrower would pay in an arm's-length transaction at the time the indebtedness is incurred. If the debt is secured by a parent entity of the facility, the average interest rate percent on the parent's total debt will be allowed unless the debt is specific to the facility and documented on the home office cost report submitted to Medicare.

(C) Interest cost includes the amortization of bond discounts and the costs related to the issuance of bonds. If a bond issue is refinanced, the unamortized bond discount and those costs related to the old bond issue are allowable costs in the year in which the refinancing takes place in accordance with generally

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accepted accounting principles. Discounts and costs of issuance must be amortized over the period from the date of sale to the date of maturity, or, if earlier, the date of retirement of the bonds.

(D) In computing allowable interest costs, interest income from the investment or lending of unrestricted funds must be deducted from allowable interest cost. Interest income from the investment or lending of restricted funds or funded depreciation need not be deducted from allowable costs as long as the interest generated from these funds accrues and is restricted to these funds. Funds that are commingled will be considered unrestricted funds.

(E) If incurred during the period of construction, loan origination fees and interest costs related to construction of a facility must be capitalized and amortized in accordance with generally accepted accounting principles.

(8) Rental and lease cost. Reasonable rent and lease costs under arm's-length operating leases are allowable costs.

(9) Depreciation.

(A) The following costs must be capitalized and not expensed:

(i) expenses for equipment with a historical cost in excess of $1,000 per unit and a useful life of more than one year after the date of purchase;

(ii) expenses for equipment with a historical cost of $1,000 or less per unit if the item was part of the initial stock of the facility.

(B) Depreciation expense for depreciable assets required in the regular course of providing patient care is an allowable cost, if it is

(i) identifiable and recorded in the facility's accounting records;

(ii) computed using the depreciation base, lives, and methods specified in this paragraph; and

(iii) recognized under Medicare principles as a depreciation allowance on facilities leased for a nominal amount as identified in the U.S. Department of Health and Human Services, Health Care Financing Administration, HCFA-Pub. 15-1, Provider Reimbursement Manual, Part 1, Section 112, dated December 1974.

(C) Depreciable assets include the following tangible assets if owned by a facility:

(i) structures;

(ii) building fixed equipment;

(iii) land improvements;

(iv) assets held by the facility through a capital lease;

(v) major movable equipment; and
(vi) minor equipment.

(D) The historical cost to the health facility of acquiring the asset in an arm's-length transaction and of preparing it for use, less amounts attributable to goodwill, is presumed to be the depreciation base. However, the department will, in its discretion, require a facility to establish the fair market value of the asset at the time of the purchase by means of an appraisal. After the appraisal is conducted, the depreciation base of the asset may not exceed its fair market value less accumulated depreciation. For long-term care facility acquisitions on or after October 1, 1985, the increase in the depreciable base is limited to one-half of the percentage increase since the date of the seller's acquisition, in the Dodge Construction Systems Cost for Nursing Homes, or, one-half of the percentage increase in the Consumer Price Index for All Urban Consumers (United States City Average), whichever is less. In addition:

(i) If depreciable assets are acquired from a related organization, the facility's depreciation base may not exceed the base the related organization had or would have had if the asset had been used for providing services to eligible state program recipients from the date of purchase.

(ii) The depreciation base of a donated asset is calculated as of the date of donation. The depreciation base of an asset received through testate or intestate distribution other than a donation is the fair market value at the date of death of the testate or intestate. However, if a donation or distribution is between related organizations, the depreciation base is the lesser of the fair market value, or the depreciation base the related organization had or would have had for the asset under a contract with the division of medical assistance.

(E) In preparing its annual budget, a facility shall account for depreciation by using useful lives for depreciable assets that are no shorter than useful lives for similar assets in the 1983 edition of "Estimated Useful Lives of Depreciable Hospital Assets," published by American Hospital Publishing, Inc.

(F) A facility shall measure the life of a depreciable asset from the date of the most recent arm's-length acquisition of the asset.

(G) A facility shall depreciate a building improvement over the remaining useful life of the building or building improvement, whichever is less, and must depreciate equipment over the remaining useful life of the equipment or over the remaining useful life of the building in which the equipment is located, whichever is less. If the remaining book value of the building is

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less than the equipment expenditure, the remaining life of the building must be evaluated for possible extension.

(H) A facility shall depreciate improvements to leased property for which it is responsible under the terms of the lease over the useful life of the improvement or the remaining term of the lease and available options to renew the lease, whichever is less.

(I) A facility may change the estimate of an asset's useful life to a longer life for the purpose of depreciation.

(J) In preparing its annual budget as required by 7 AAC 43.679, and in accordance with the provisions of the manual, a facility shall depreciate buildings, land improvements, and equipment, using the straight-line method.

(K) If depreciable assets are permanently abandoned or disposed of through sale, trade-in, scrapping, exchange, theft, wrecking, or fire or other casualty, a facility may no longer depreciate the assets, and the assets are considered retired assets.

(L) A gain or loss on the retirement of an asset is the difference between the remaining undepreciated base of the asset and any proceeds due from the retirement of the asset.

(M) If a retired asset is replaced, a facility shall deduct the gain from the depreciation base of the replacement asset in its annual budget or budget amendment. The loss to the depreciation base of the retired asset, if any, may be added to the depreciation base of the replacement asset if the facility has made reasonable effort to recover at least the undepreciated base of the retired asset.

(10) Costs authorized by a certificate of need.

(A) Interest, depreciation, and other capital costs will not be recognized on assets purchased after January 18, 1990 if a certificate of need was required and the facility did not secure one. Recognition of interest, depreciation, and other capital costs for which a certificate of need was required will be no greater than the amounts described within the certificate of need application and other information the applicant provided as a basis for approval of the certificate of need.

(B) Prospective payment rates for facilities which are calculated and paid on a per diem rate basis will be no greater than the per diem rates proposed within the certificate of need application and other information the applicant provided as a basis for approval of the certificate of need for a period of 24 months following:

(1) opening of the new or modified health care facility;

(2) alteration of the bed capacity; or

(3) the implementation date of a change in offered categories of health service or bed capacity.

(C) In determining whether interest, depreciation, and other capital costs exceed those amounts approved under a certificate of need, and for determining the maximum prospective per diem rate approved under a certificate of need, the department will consider

(1) the terms of issuance describing the nature and extent of the activities authorized by the certificate; and

(2) the facts and assertions presented by the facility within the application and certificate of need review record, including purchase or contract prices, the rate of interest identified or assumed for any borrowed capital, lease costs, donations, development costs, staffing and administration costs, and other information the facility provided as a basis for approval of the certificate of need.

(D) If a certificate is issued, authorizing only part of the activities proposed within a certificate of need application, the limitation of rates will be based upon the factors noted under (C) of this paragraph.

(11) Limits on operating costs provided by related organizations. Costs of services, facilities, and supplies furnished to a facility by organizations related to the facility are allowable costs only to the extent that these costs do not exceed the lower of

(A) the documented costs of the services, facilities, or supplies to the related organization; or

(B) the reasonable price of comparable services, facilities, or supplies offered by a vendor not related to the facility.

(12) Related organization cost documentation. A facility shall document the cost to a related organization for services, facilities, or supplies furnished to the facility by the related organization. The department will permit the cost to be included in the operating base of a prospective payment rate only if the cost to be included is fully documented as prescribed in the manual.

(13) Pharmaceutical supplies and materials. Pharmaceutical supplies and materials as defined in the manual for recipients who are residents of a long-term care facility, or an intermediate care facility for the mentally retarded, are reimbursed in accordance with 7 AAC 43.255(b) and 7 AAC 43.312(a). These costs, with the exception of the costs of nonprescription drugs dispensed as ordered by a physician, are excluded from facility prospective payment rates.

(e) OBRA '87-related nurse aide training and competency evaluation incremental costs as described in 7 AAC 43.695 are excluded from allowable operating costs. (Eff. 8/9/86, Register 99; am 7/20/88,